Testimony of

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before the
HOUSE COMMERCE SUBCOMMITTEE ON HEALTH & ENVIRONMENT
on
TELEMEDICINE

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Chairman Bilirakis, Congressman Brown, distinguished Subcommittee members, thank you for inviting me to discuss Medicare coverage of telemedicine. Telemedicine, with its ability to provide medical services via telecommunications systems, holds great promise for extending access to care in rural and other medically underserved areas. We understand that rural beneficiaries face unique challenges in accessing the medical care they need, particularly access to specialists. Helping them is a high priority for us. And we share the Secretary's commitment to promoting telemedicine where appropriate.

To date, telemedicine usage in Medicare has been limited. The Balanced Budget Act (BBA) of 1997 expanded coverage options, but also included several restrictions that preclude telemedicine's use under conditions where it is commonly being used outside of Medicare. We are concerned that this is limiting the potential of telemedicine in Medicare. However, we also have a number of concerns regarding broader implementation of telemedicine. There is very little published, peer-reviewed scientific data available on when telemedicine use is medically appropriate. It is difficult to project potential cost implications. And there are potential program integrity issues that should be addressed proactively.

To help address these concerns, we are conducting extensive research and several demonstration projects. We are particularly interested in learning more about:

- specific clinical circumstances when telemedicine is medically appropriate;
- which health care providers are clinically appropriate for telemedicine presentations; and,
- the potential uses and abuses of "store-and-forward" technology, in which there is no real-time interaction between patient and provider.

We are conducting demonstration projects specifically examining:

- the feasibility, acceptability, cost, and quality of teleconsultation services;
- the potential role of telemedicine in diabetes management; and,

- rural physicians' perceived barriers to utilizing telemedicine.

We also are consulting with academic and military experts who are using telemedicine in situations beyond those now allowed under the Medicare statute. We are working with other Department of Health and Human Services agencies, including the Health Resources and Services Administration's Office of Rural Health Policy and Office for the Advancement of Telehealth, as well as the Agency for Healthcare Research and Quality. In addition, the Department's Assistant Secretary for Planning and Evaluation has commissioned a study on assessing approaches to evaluating telemedicine, which should further enlighten our work.

These efforts are ongoing, and we are not yet able to reach firm conclusions or make responsible recommendations. As mentioned above, there is very little published, peer-reviewed scientific data in this field, which makes our current research efforts all the more critical for determining how telemedicine coverage should be expanded. However, preliminary indications from our ongoing work suggest there may well be additional clinical circumstances, beyond those paid under current Medicare law, where telemedicine is appropriate. There also may well be additional health care personnel able, but not allowed under current law, to make telemedicine presentations. We will continue our telemedicine research efforts and compile findings in a report that will make firm recommendations on how the benefit should be expanded and what program integrity protections may be needed. We want to work with Congress as we proceed to develop the data necessary for responsible decisions about how to expand the use of telemedicine in Medicare.

To further help us in all our efforts to better serve rural beneficiaries and providers, including the use of telemedicine services, we have established a Rural Health Initiative within our agency. This Initiative includes senior agency leaders and a direct rural contact staffer in each of our Regional Offices to increase and coordinate attention to rural issues and closely monitor how laws and regulations governing our programs affect rural beneficiaries and providers.

Background

The BBA significantly expanded Medicare's authority to cover telemedicine. Previously, telemedicine coverage in Medicare was limited to situations in which no face-to-face contact between patient and provider is generally necessary; for example, in radiologic interpretation of x-rays. However, the BBA expansion continued to place strict limits on telemedicine coverage. For example:

- Telemedicine services may only be provided to a beneficiary in a rural health professional shortage area (HPSA);

- Telemedicine services are limited to "consultations" for which payment currently may be made under Medicare. This is a key limitation, as the American Medical Association Physicians' Current Procedure Terminology (CPT) defines consultation as a "face-to-face" physician and patient encounter, meaning that the patient must be present at the time of the consultation. Therefore, a Medicare "teleconsultation," is a medical examination under the control of the consulting practitioner, in lieu of an actual face-to-face encounter, that must take place via an interactive audio-video telecommunications system;

- Only physicians or practitioners described in section 1842(b)(18)(C) of the Social Security Act may provide teleconsultations. This also is a key limitation, as registered nurses and other medical professionals not recognized as practitioners under this section of the Medicare statute may not receive payment for a teleconsultation, even though they commonly serve as telepresenter outside of Medicare. Additional health care professionals, such as clinical psychologists, clinical social workers, and physical, occupational, or speech therapists who are able to receive Medicare payment in limited circumstances, but are not specifically listed in the statute as Medicare providers, also are precluded from receiving payment for teleconsultation; and,

- The law specifically prohibits payment for line charges or for facility fees, and mandates that consulting and referring practitioners share payments.

On November 2, 1998, we published a final rule in the *Federal Register* implementing the telemedicine provisions of the BBA. The rule explains the geographic limits for reimbursement, the practitioners that are eligible to present patients and act as consultants, the teleconsultive services and technologies that are covered, and how payment will be made.

Regarding the mandate that consulting and referring practitioners must share payments, the rule stipulates that 75 percent of the fee go to the consultant and the remaining 25 percent go to the referring practitioners. This split is based on the relative work for practitioners at both ends of the consultation and an inherent recognition that different consultations call for different levels of effort. As a result, the fee split reflects the projected level of new work done by each practitioner over the course of various teleconsultations.

The rule also specifies that the eligible CPT codes for consultations that can be covered under the statute can be used for a number of medical specialties, such as cardiology, dermatology, gastroenterology, neurology, pulmonary, and psychiatry. We will cover additional consultations for the same or a new problem if the attending physician or practitioner requests the consultation, and if it is documented in the medical records of the beneficiary.

Telemedicine in Other Setting

Outside of Medicare, telemedicine is being used in many circumstances not allowed under current Medicare law. Again, there is a paucity of published, peer-reviewed literature on the appropriateness of many of these uses. However, telemedicine is being used for much more than interactive consultations. These include evaluation and management services that are common in physician office visits, psychotherapy, pharmacologic management, sleep studies, physical and occupational therapy evaluation, and speech therapy.

"Store-and-forward" technology also is being used in which there is no real-time interaction between patient and provider. Instead, a referring provider will examine a patient and then send a video clip or a photographic scan, along with the patient's medical record, to a distant consulting practitioner. The consulting practitioner will then review the file and make a diagnosis. Military and academic health care providers, in particular, are having apparent success with "store-and-forward" for diagnosing dermatology cases. And it is being used for several other specialties, such as opthalmology, cardiology, nuclear medicine, and sleep.

Also, outside of Medicare, telemedicine presentations are commonly made by health care

professionals, especially registered nurses and licensed practical nurses, who are not allowed to make such presentations under current Medicare law. Some telemedicine programs use nurses for virtually all telepresentations, with generally high satisfaction ratings from both patients and physicians. And we are examining this through one of our demonstration projects where we are allowing registered nurses to make telemedicine presentations.

In Medicaid, at least 17 States (Arkansas, California, Georgia, Iowa, Illinois, Kansas, Louisiana, Montana, Nebraska, North Carolina, North Dakota, Oklahoma, South Dakota, Texas, Utah, Virginia, and West Virginia) are covering telemedicine, often under circumstances not now allowed under Medicare law. States must satisfy Federal requirements of efficiency, economy, and quality in telemedicine coverage, but generally are encouraged to use the flexibility inherent in Federal law to create innovative payment methodologies for telemedicine. For example, States are not required to split fees as in Medicare, and may make separate reimbursements to both the referring physician for an office visit and to the consulting physician for a consultation. States also can cover network line charges, facility fees, technical support, depreciation on equipment, and other costs not allowed under Medicare law, as long as the payment is consistent with the requirements of efficiency, economy, and quality of care.

Current Research

We recognize the potential benefits these additional telemedicine uses may offer in Medicare. But we feel compelled to proceed with due caution because of the paucity of published, peer-reviewed scientific literature on when and where these other uses are clinically appropriate. We also are concerned about the effect of telemedicine on quality or care, the potential for abuse, and the difficulty in establishing program integrity parameters without the kinds of solid, scientific, evidence we generally rely on in determining when a given service is medically appropriate.

To address these outstanding concerns, we are conducting extensive research and demonstration projects, and developing a report that will include specific recommendations on how to expand the Medicare telemedicine benefit. To collect data on these issues, we have worked with telehealth projects receiving grant funding through the Office for the Advancement of Telehealth at the Health Resources and Services Administration. We also received data from the telemedicine directorate at the Walter Reed Army Medical Center and the Telemedicine Center at Ohio State University Medical Center.

Also, in conjunction with the Agency for Healthcare Research and Quality, we have contracted with the Oregon Health Sciences University to evaluate several issues pertaining to Medicare coverage policy. These efforts have helped us understand how telemedicine is being used outside Medicare. This study involved an assessment of the clinical and scientific literature dealing with the cost-effectiveness of telemedicine, specifically looking into the areas of "store-and-forward" technology, patient self-testing and monitoring, and potential telemedicine applications for non-surgical medical services.

Within Medicare, we are conducting research demonstration projects to help us better understand telemedicine. We are working through Columbia University to conduct the Informatics, Telemedicine, and Education Demonstration Project, as required by the BBA. This randomized, controlled study will explore whether the use of advanced telemedicine technology improves clinical outcomes for diabetics in New York City and rural, upstate New York.

Another demonstration to assess the feasibility, acceptability, cost, and quality of teleconsultation services involves 110 Medicare-certified facilities in North Carolina, Iowa, West Virginia, and Georgia. It also includes a bundled payment rate that is negotiated to cover both the facility and physician fees for telemedicine services. Utilization of telemedicine in the project so far has been limited. And we are now considering whether to remove the bundled payment feature, which may be contributing to the low utilization levels, from the project. To better understand usage patterns, we also are examining rural providers' perceived barriers to telemedicine.

We also are examining whether it is appropriate to provide payments for teleconsultation to beneficiaries in homebound settings. And we also are working with the Center for Health Policy Research at the University of Colorado to evaluate the impact of telemedicine coverage on access to, and quality of, care, and to analyze rural physicians' perceived barriers to telemedicine.

A key concern for us as we work with Congress in exploring possible expansions is how to ensure that telemedicine is used appropriately. There is significant potential for over-utilization that would be difficult to monitor and prevent, since we have so little data to guide us in determining when telemedicine is, in fact, medically appropriate. "Store-and-forward" technology, in particular, has the potential to substantially increase the number of consultations billed to Medicare without regard to medical necessity.

Another key concern is the difficulty in projecting costs for telemedicine expansions. There are, as yet, no good data on the extent to which expanded coverage for telemedicine would increase claims. There are no reliable data on the extent to which additional claims would represent appropriate care that should be, but is not now, being delivered. And there are no reliable data on the extent to which expanded coverage would invite inappropriate claims or other abuse. The lack of data, as well as program and payment experience, in these areas warrants a careful, measured approach as we proceed. Issues such as scope of coverage and expansion of eligible areas need to be carefully studied and considered. And we need reliable evidence to determine when telemedicine is an appropriate substitute for services that traditionally require the physical presence of a patient.

Rural Initiative

Telemedicine is only one part of our efforts to improve access and services for rural beneficiaries. We are redoubling our efforts to more clearly understand, and actively address, the special circumstances of rural providers and beneficiaries. Last year we launched a new Rural Health Initiative and are meeting with rural providers, visiting rural facilities, reviewing the impact of our regulations on rural health care providers, and conducting more research on rural health care issues. We are participating in regularly scheduled meetings with the Health Resources and Services Administration's Office of Rural Health Policy to make sure that we stay abreast of emerging rural issues. And we are working directly with the National Rural Health Association to evaluate rural access to care and the impact of recent policy changes.

Our goal is to engage in more dialogue with rural providers and ensure that we are considering all possible ways of making sure rural beneficiaries get the care they need, including use of telemedicine. We are looking at best practices and areas where research and demonstration projects are warranted. We want to hear from those who are providing services to rural

beneficiaries about what steps we can take to ensure they get the care they need.

We have put together a team for this rural initiative that includes senior staff in our Central and Regional Offices and dedicated personnel around the country. The work group is co-chaired by Linda Ruiz in our Seattle regional office and Tom Hoyer in our central office headquarters in Baltimore. Each of our ten regional offices now has a rural issues point person that you and your rural provider constituents can call directly to raise and discuss issues, ideas, and concerns. A list of these contacts and their respective States is attached to my testimony.

Conclusion

Telemedicine holds great promise for improving access to care, particularly for beneficiaries in rural and other underserved areas. Our ongoing research efforts should help address the lack of scientific data on its appropriate uses. That will help us understand whether and how current restrictions on Medicare coverage for telemedicine should be changed.

We are very grateful for this opportunity to discuss our efforts to help rural providers and beneficiaries, and to explore further actions we might take to address their concerns in a prompt and fiscally prudent manner. I thank you again for holding this hearing, and I am happy to answer your questions.

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